ised to introduce legislation by the fall of 1980 that will prevent balance billing. This is likely to cause considerable unrest among members of the profession. Most of the general public is indifferent to the issue of balance billing; however, a few political activists have stirred up trouble over this matter.

The Grande Prairie General Hospital has been unable to reopen fully after the nurses' strike because of staff shortages. It is becoming increasingly difficult to find nurses, physiotherapists, occupational therapists, dietitians and radiographers. A new larger hospital is presently under construction. New hospitals in other parts of Alberta are working at reduced capacity because of similar staff shortages.

Mr. Lougheed and his followers should concentrate their efforts more on doing a good job with the existing facilities and providing an environment that will attract health care workers to the province, rather than promoting grandiose schemes to turn Alberta into the medical brain centre of Canada. However elaborate and lavish the hospitals and institutes, they are of limited value if they are closed for lack of staff. To claim that the establishment of various advanced institutes would attract staff and that this would spill over into the periphery is to try running before walking or even crawling.

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Canadian Plasma Exchange Study Group needs input from physicians

To the editor: Plasma exchange is becoming widely used in the treatment of a variety of immunologic and other disorders. For many diseases there are conflicting reports on the value of plasma exchange and few prospective controlled clinical trials have been done. Because of the potential scope of this problem the Department of National Health and Welfare has undertaken to fund a study group to coordinate the establishment of protocols to assist interested groups in gathering data on plasma exchange.

To restrict activities to the most pertinent areas and to design the study protocols appropriately, the members of the Canadian Plasma Exchange Study Group require the widest possible input from interested physicians. Therefore, anyone interested or involved in the treatment of disease by plasma exchange is encouraged to communicate either with the president of their subspecialty or with a member of the study group's planning committee (myself or Drs. N.A. Buskard, Vancouver; M. Katz, Montreal; K.H. Shumak, Toronto; D.M.C. Sutton, Toronto; or R.G. Préfontaine, coordinator, Ottawa) to assist in the establishment of these protocols.

We recognize that the establishment of controlled Canadian trials is a considerable undertaking. However, we hope that with the support of the federal government and the physicians involved in therapeutic plasma exchange we will be able to collect sufficient data to lead to a better understanding of both treatment regimens and disease mechanisms. Owing to the medical climate in Canada, we have a particularly appropriate environment to undertake the establishment of such protocols. If any readers of the Journal have an interest in this area we would appreciate hearing from them.

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Emergency department staffing

To the editor: Dr. I. Feferman's letter (*Can Med Assoc J* 122: 284, 1980) was of interest to me as I have continued to do regular emergency shifts while in an active family practice.

However, before we accept his recommendation that emergency departments should be staffed by full-time emergency specialists, the impact of this recommendation on medicine in the community needs to be considered.

When family physicians are barred from the emergency department their skills in emergency and acute care diminish. After 5 years without emergency work will I remember how to efficiently treat an anaphylactic reaction in my office? How anxious will I be to stop at the scene of an accident when I haven't seen an acutely traumatized patient in years? What will I remember of cardiopulmonary resuscitation? These few examples illustrate that the barring of family physicians from emergency work will seriously diminish their ability to treat emergencies occurring in their offices and in the community.

Diminished responsibility in the emergency setting will further reduce contact between general and family physicians and hospitals. My emergency responsibilities now lead to frequent personal contact with consultants, colleagues and interns, and I attend emergency and other rounds at the hospital. My continuing education and general competency cannot help but be improved.

Family physicians need to be encouraged to take on emergency care responsibilities to maintain vital skills in the community. Continuing education should be required so that adequate emergency skills can be maintained.

Full-time emergency physicians are required when local physicians are unwilling or unable to take on emergency department responsibilities, but it does not follow that this should be the rule in all areas.

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Legal abortions among teenagers in Canada, 1974 through 1978 [correction]

In the byline of this article (*Can Med Assoc J* 122: 1386, 1980) the first author's name is incorrectly given as A. Wadhera; it is, in fact, S. Wadhera. — Ed.

Nonspecific arousal with naloxone [correction]

In this article (*Can Med Assoc J* 123: 33, 1980), by Finkelstein, Bayne and Rangno, the sentence beginning on the 34th line of the fifth column should read: "Mayer, Price and Rafii[7] demonstrated that acupuncture analgesia is *reversed* [italics added] by naloxone." — Ed.